

## **BOARD OF OPTOMETRY**

400 R STREET, SUITE 4090, SACRAMENTO, CALIFORNIA, 95814-6200 (916) 323-8720 / (800) 547-4576



FOR OFFICE USE ONLY

CASE #\_

## CONSUMER COMPLAINT FORM

	Ac	ction Taken
		D#
Please Print or Type		
PERSON REGISTE	RING COMPI	LAINT
Name:		Home Phone
Address:		Business Phone
City	State	
I authorize the State Board of Optometry to provide a copy or summar patient records from the optometrist if necessary.	y of this complaint to	the optometrist, and to obtain a copy of my
Signature		Date
COMPLAINT REG	ISTEDED AC	AINCT
Name of the optometrist:	ISTERED AG	AIIVSI
Address:		Business Phone
City:	State	Zip Code
DETAILS OF	COMPLAINT	
1. Have you discussed this matter with the optometrist?		ussed this matter with your local optometric
YES NO	society, other o	organization or other eye care professional?
		YES NO
When:	Whom	
Result:	WHOIII.	
	***	
	Result:	
3. Have you contacted an attorney or filed a claim in Small Claims		
Court?		
YES NO NO		
4. Date of eye examination and /or date of delivery of ophthalmic de	vices?	

39M-11 (Rev 8/99) 1 Continued on reverse side

5. State the pertinent details of your complaint:		
- · · · · · · · · · · · · · · · · · · ·		
6. What would you consider to be a satisfactory resolution to your complain	nt?	
7. I certify that all information which I have given herein to be true, correct and complete to the best of my knowledge.		
The recent of the control of the recent of the recent of the control of the contr		
<u> </u>		
Signature	Date	

Please attach additional information or evidence you may have to support your allegation(s) to this form.